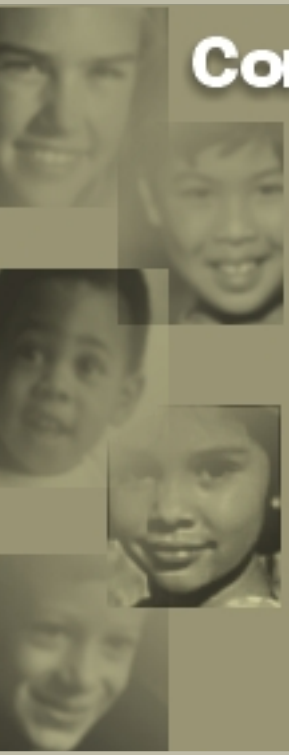

Community Care of North Carolina

ACCESS II & III

“ Improving Medicaid Quality by Building Community Systems of Care”

L. Allen Dobson ,Jr. MD FAAFP
Assistant Secretary
NC Department of Health & Human Services

Major Department Goals

- Medicaid Reform (CCNC)
- Mental Health Reform
- Health Disparities
- MMIS change- NC Leads

Vision: Innovation and Collaboration

The Cost Equation

Eligibility/Benefits + Reimbursement Rate + Utilization = Cost

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- Eligibility and Benefits - who you cover and what you cover
- Reimbursement - what you pay
- Utilization - how much services are provided

We just have to figure out how to manage utilization!!!

Current NC Medicaid Facts

- 1.2 million unduplicated eligibles covered (15.2% 0f population)
- 686,000 children covered
- 45% of all babies born covered
- 30 % of recipients consume 74.5% resources
- Inpatient care (hosp,NH,MRC) consumes 40%
- Physicians account for only 9-10% of costs!!!
- Over $1 billion spend on mental health services
- **Total budget over $ 9 billion**

Improving Quality
&
Controlling Medicaid Costs

Developing Community Care of NC

ISSUES:

- No real care coordination system at the local level
- Providers feel limited in their ability to manage care in current system
- Local public health departments and area mental health services are not coordinated with the medical care system
- Duplication of services at the local level
- State “Silo Funding”

Primary Goals of Medicaid Effort

- *Improve the care of the Medicaid population while controlling costs*
- *Develop Community based networks capable of managing populations*

Basic Operating Premise

- Regardless of who manages Medicaid, the hospitals, physicians and safety net providers in NC serving patients remain the same and must be engaged
- We need to transform state Medicaid management from a regulatory function to a health care management function
- We must carefully balance cost containment with quality improvement efforts
- Decision making must be driven by data & outcomes monitored
- We must help transform healthcare system from acute care model to chronic illness model

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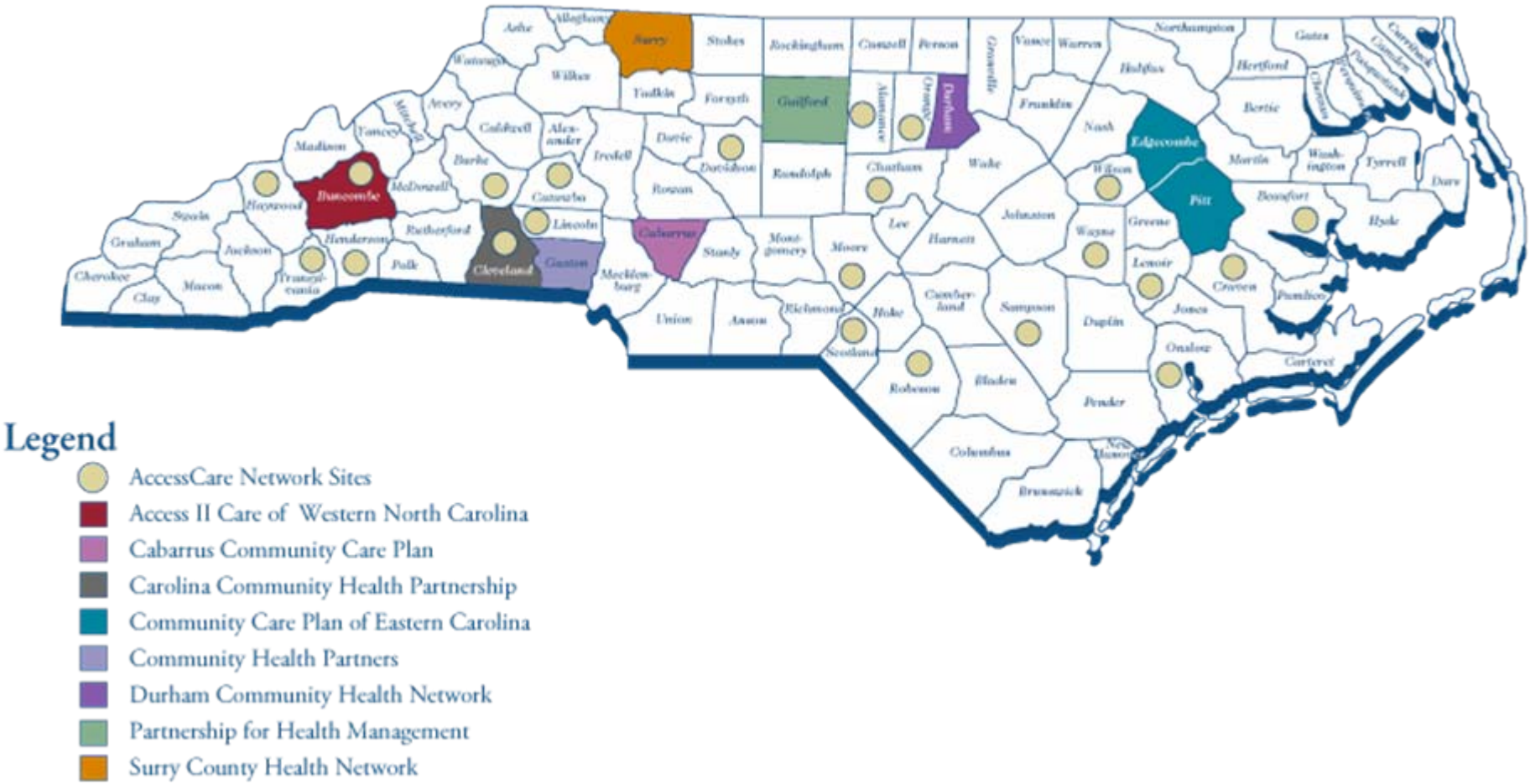
Build on ACCESS I (PCCM) 1998-99 as pilot program

- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Creates community networks that assume responsibility for managing recipient care

Community Care of North Carolina (Access II and III Networks)

1999

Then



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Now in 2006

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 15 Networks with more than 3500 Primary Care Physicians (medical homes)
- over 715,000 enrollees

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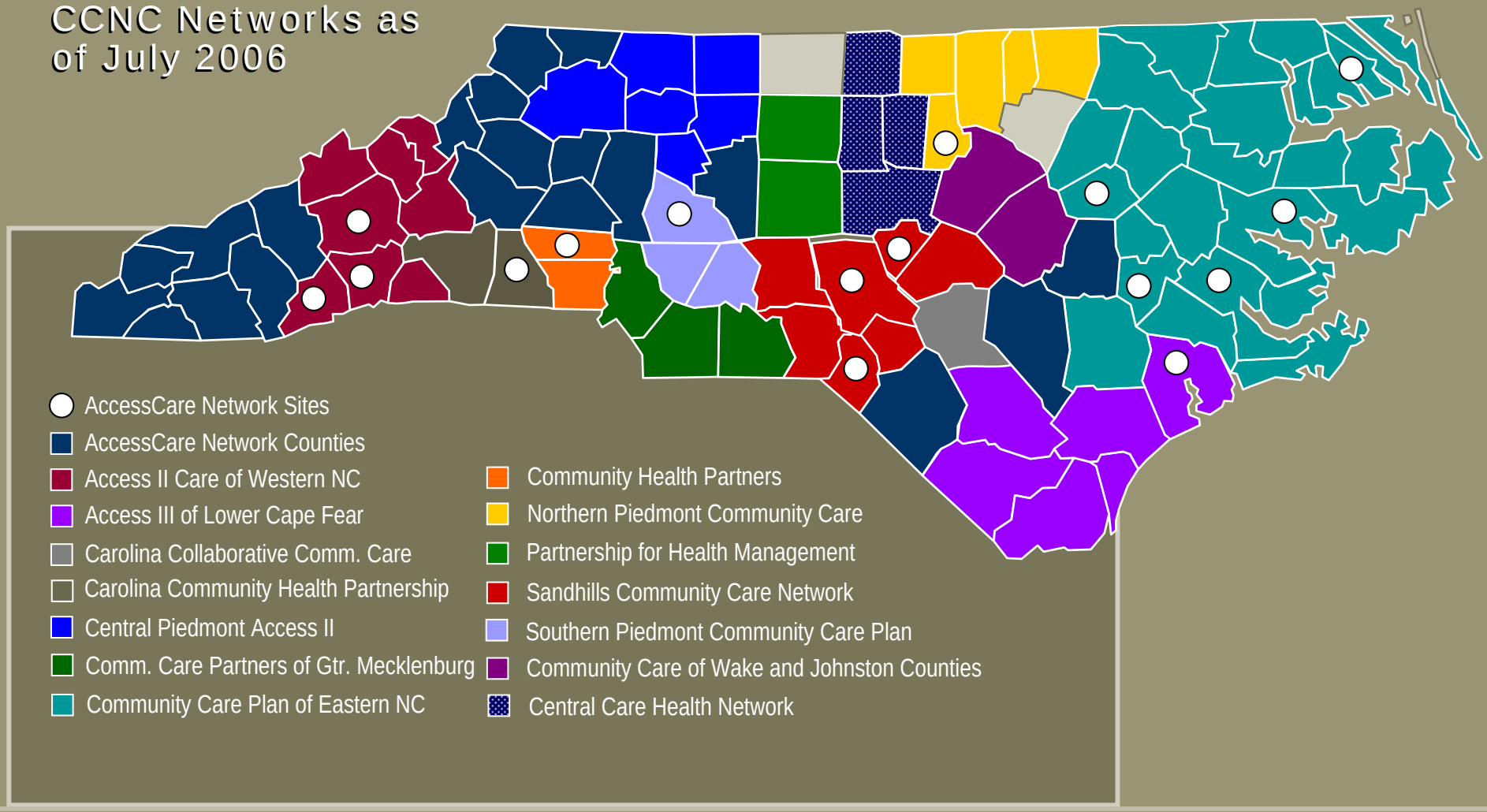
CCNC Networks as of July 2006



Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive $2.50 PM/PM from the State
- Hire care managers/medical management staff
- PCP also get $2.50 PMPM to serve as medical home and to participate in DM

What Networks Do

- Assume responsibility for Medicaid recipients
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability
- **Implement improved care management and disease management systems**

Guidelines for Selecting a Quality Improvement Initiative

- There are enough Medicaid enrollees with the disease to obtain a "return on investment."
- Evidence exists that best practices lead to predictable and improved outcomes.
- Appropriate evidence-based practice guidelines are available.
- Best practices and outcomes are measurable, reliable, and relevant.
- There is room for improvement - a gap exists between best practice and everyday practice.
- There is a measurable baseline and thus an ability to measure improvement.

Physicians must be supportive

Current State-wide Disease and Care Management Initiatives

- Asthma
- Diabetes
- Pharmacy Management (PAL, NH poly-pharmacy)
- Dental Screening and Fluoride Varnish
- Emergency Department Utilization Management
- Case Management of High Cost – High Risk
- Congestive Heart Failure (CHF) (2006)

Network Specific Quality Improvement Initiatives

- "Assuring Better Child Development" (ABCD)
- ADD/ADHD
- HCAP/Coordinated care for the uninsured
- Gastroenteritis (GE)
- Otitis Media (OM)
- Projects with Public Health (Low Birth Weight, open access & diabetes self management)
- Diabetes Disparities
- Medical Home/ED Communications

New Network Pilots

- Aged, Blind and Disabled (ABD)
- Depression Screening and Treatment
- Mental Health Integration
- Mental Health Provider Co-location
- E- Rx
- Medical Group Visits
- Dually Eligible Recipients

Asthma and Diabetes Initiatives
Asthma began 1998 Diabetes began 2000

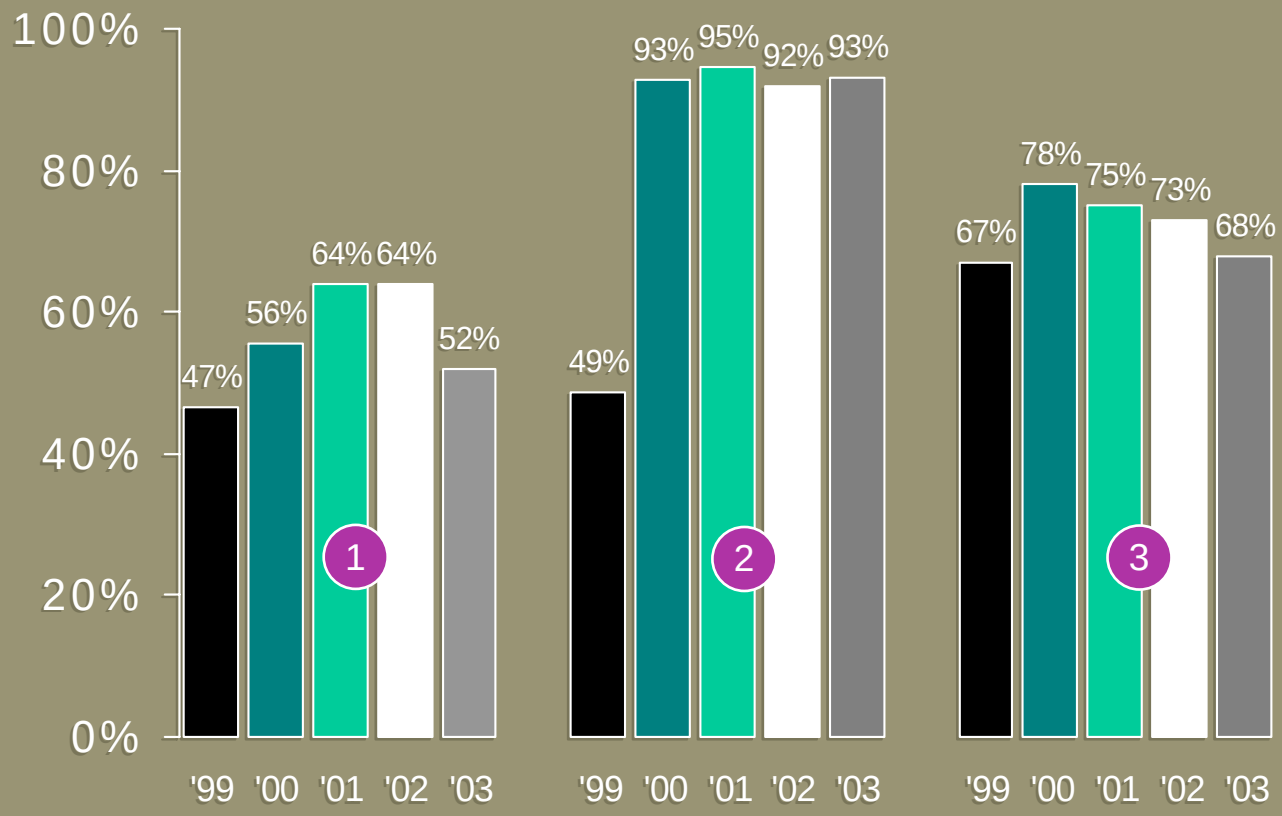
- Adopted nationally accepted best practice guidelines
- Physicians set performance measures
- Provide regular monitoring and feedback
- Implement CQI at practice level

Asthma Measures

- Percentage of asthma patients staged
- Percentage of asthma patients staged II, III, and IV on maintenance medications
- Percentage of asthma patients with a written Asthma Management Plan
- Percent of asthma patients receiving an annual influenza vaccine

Asthma Initiative

Process Measures



Key

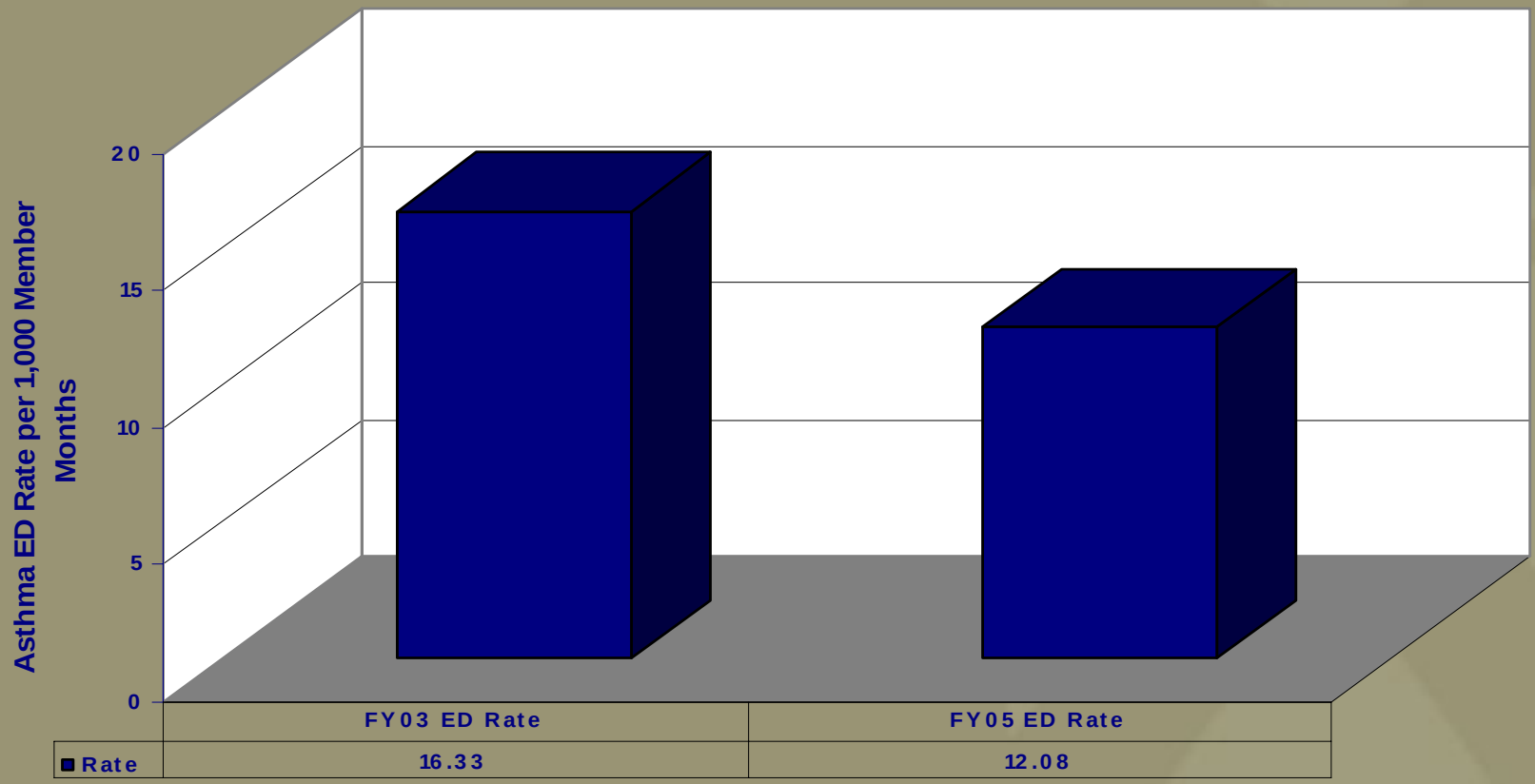
1. % with asthma who had documentation of staging
2. % staged II – IV on inhaled corticosteroids
3. % staged II – IV who have an AAP

Key Results

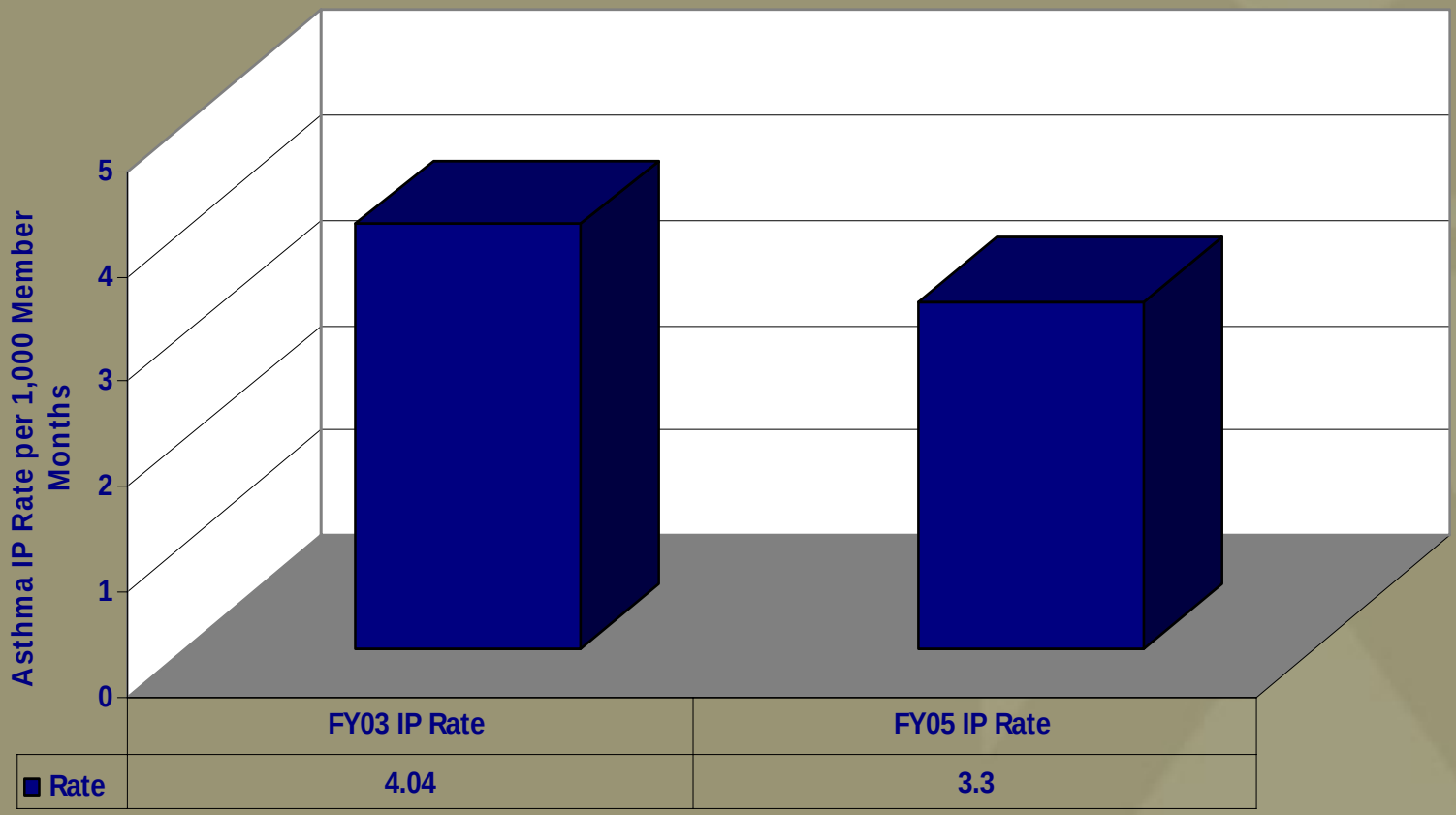
Asthma

- 18% lower hospital admission rate for enrollees under 21 than in the control group, and an 26% lower ED rate than in the control group the average episode cost for children enrolled in CCNC was 24% lower than those not enrolled in the program (CCNC cost per episode = $687 versus $853)
- 93% received appropriate inhaled steroid
- 21% increase in the number of patients with asthma who have been staged and a 112% increase in the number of asthmatic patients receiving flu vaccines

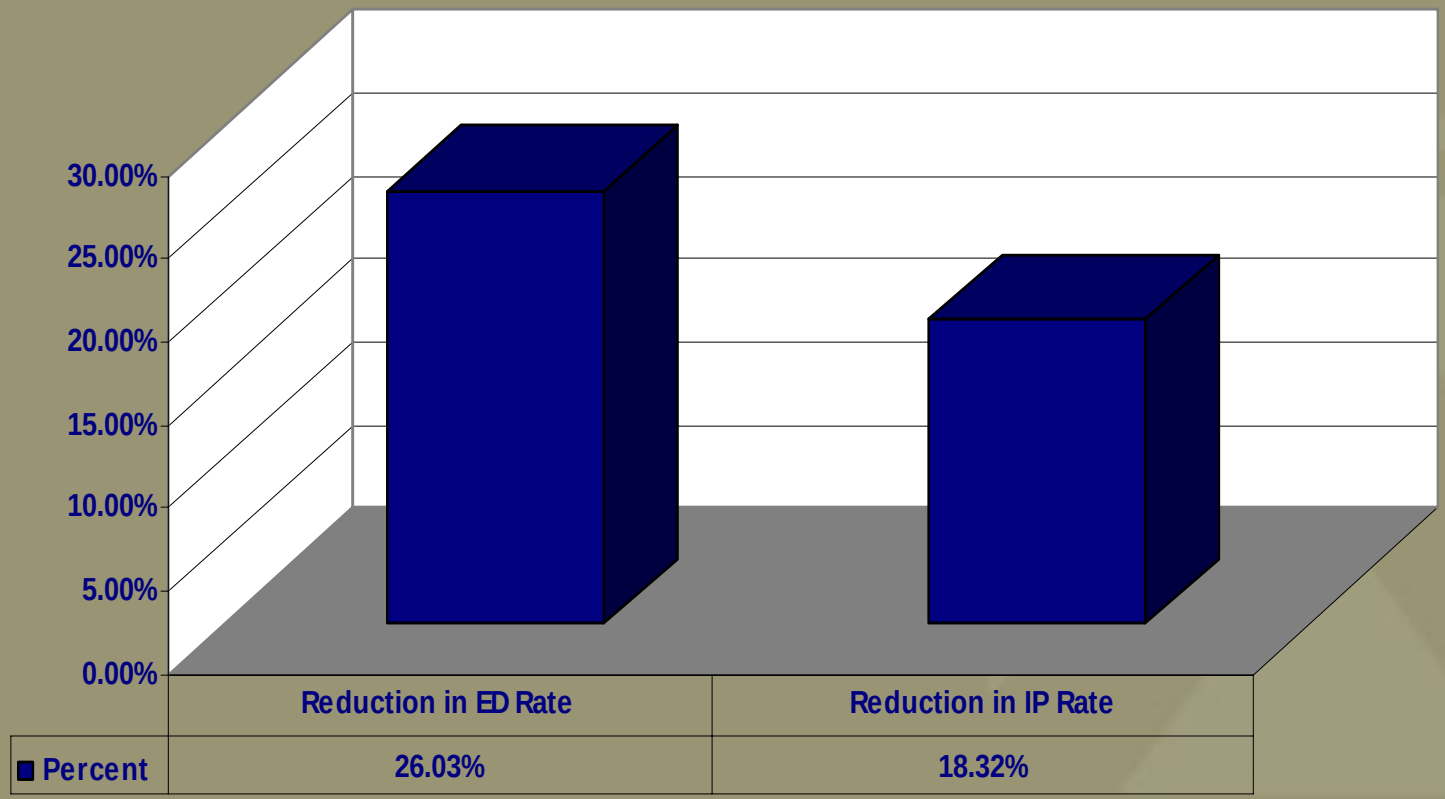
CCNC Asthma ED Rates for FY2003 and FY2005



CCNC Asthma Inpatient Rates for FY2003 and FY2005



Percent Reduction in Asthma ED and Inpatient Admissions Between FY2003 and FY2005



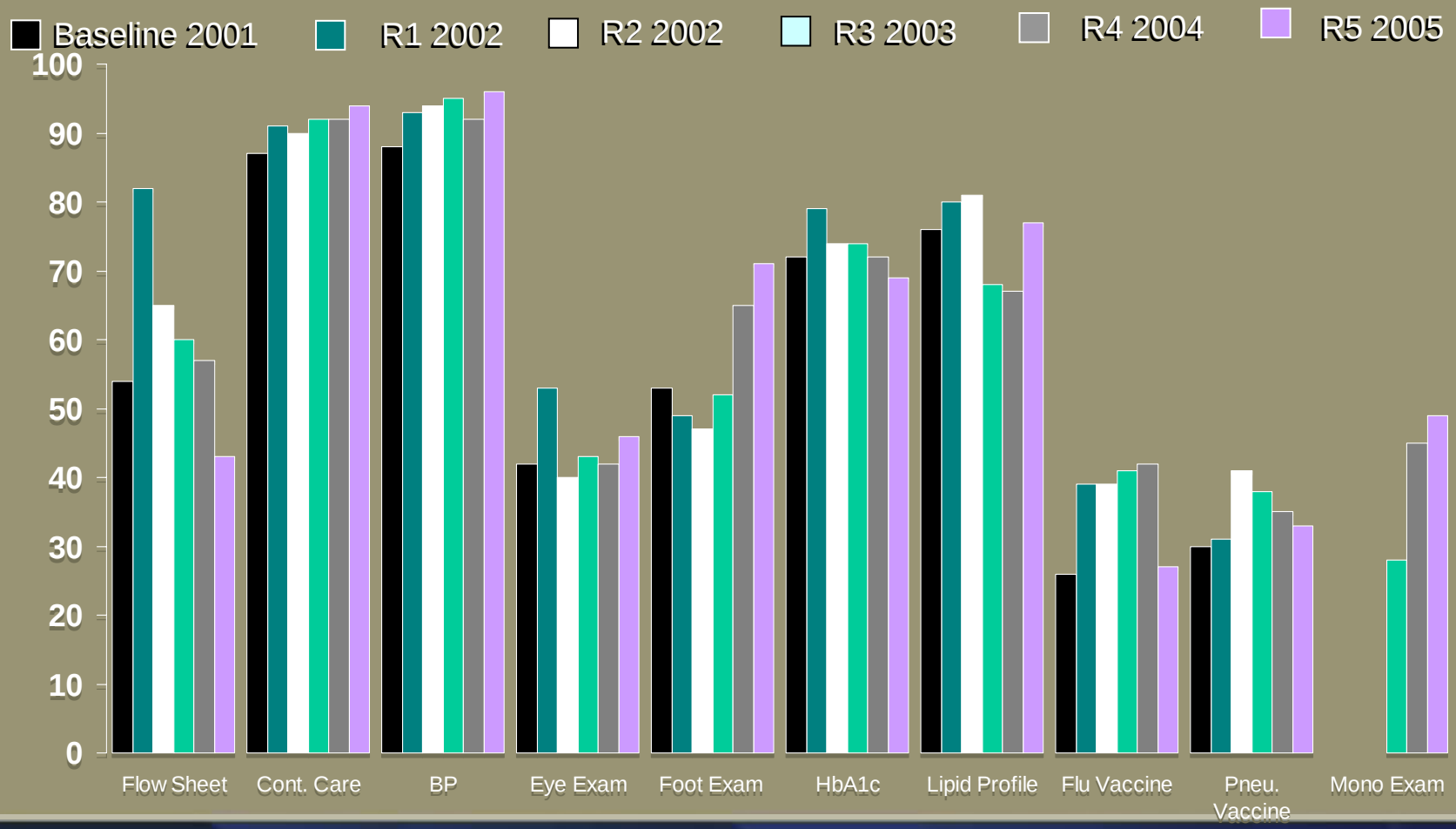
Diabetes Measures

- Diabetic Flow Sheet in use on the medical record
- Continued care visits at least 2 x year
- Blood pressure at every continuing care visit
- Referral for dilated eye / retinal exam every year
- Foot exam every year
- Monofilament / sensory exam every year
- Glycosylated Hemoglobin (HgbA1c) at least 2 in 12 months
- Annual Lipid profile
- Annual Flu Vaccine
- Pneumococcal vaccine done once (repeat IF first dose was given at <65 yrs. old AND pt. is now >65 AND first dose was given > 5 yrs ago)

Diabetes Initiative

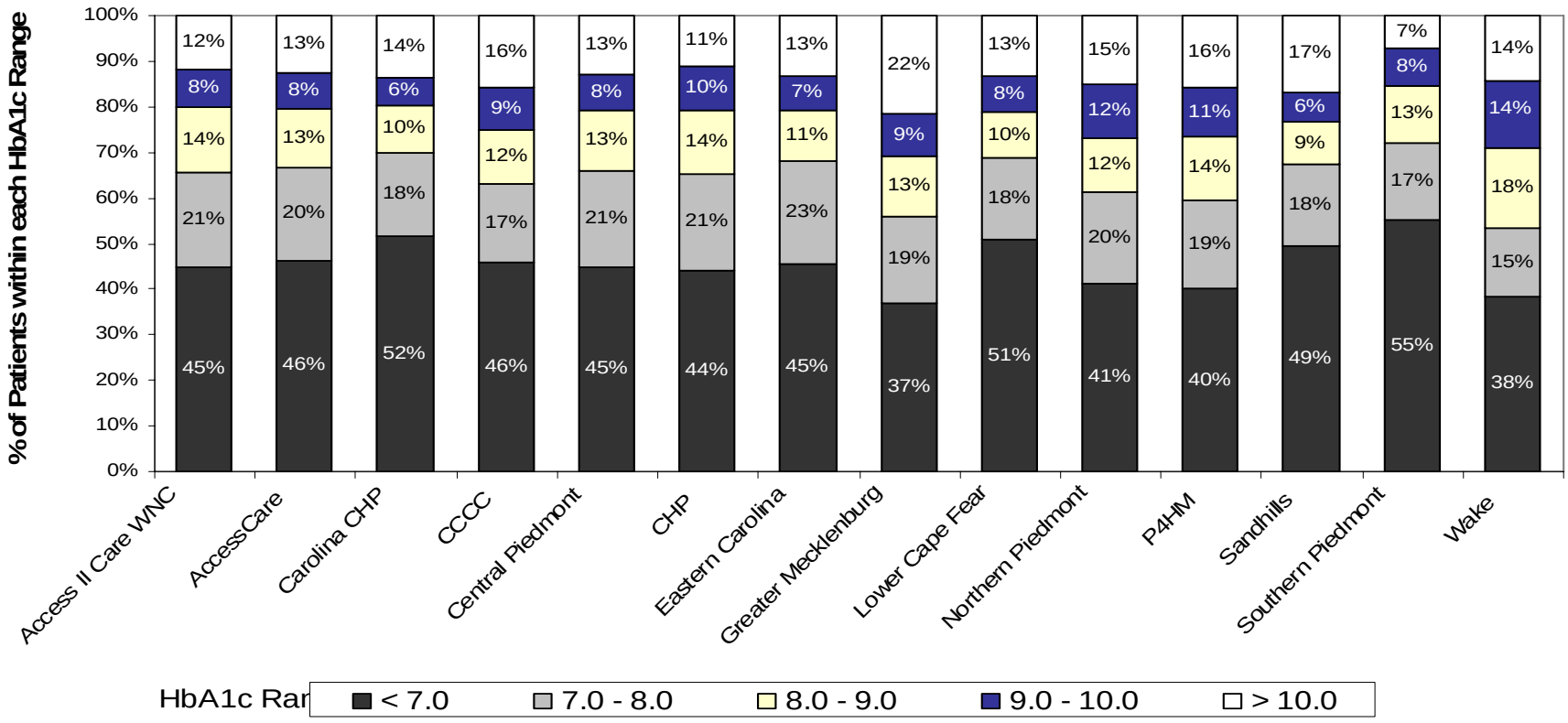
Process Measures

Community Care of NC Diabetes Quality Initiative Summary (Established)



Community Care of North Carolina
Diabetes Disease Management Quality Initiative
Round 5 2005

Distribution of HbA1c Values



Gathering and Sharing the Results

- Utilizing claims data
- Chart Audits (contract with NC AHEC)
- Practice profiles

Example Practice Profile

Cost/Benefit Estimates

Community Care of North Carolina

July 1, 2002 – Jun 30, 2003

- Cost - $8.1 Million

  (Cost of Community Care operation)

- **Savings - $60,182,128 compared to FY02**

- **Savings- $203,423,814 compared to FFS**

  (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)

Cost Savings for SFY 2004

July 1, 2003- June 30, 2004

- Cost - $10.2 million

  (cost of CCNC operations)

- **Savings- $124 million compared to SFY 03**
- **Savings $225 million compared to FFS**

Want to Know More?

www.communitycarenc.com

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Thank You

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